
# Review of the Basic Health Program Option for Rhode Island

January 2013

Rhode Island General Law Section 40-8.4-14(g) directs the Office of the Health Insurance Commissioner and the Executive Office of Health and Human Services (EOHHS) to issue a series of reports to the Joint Committee on Healthcare Oversight on state implementation options related to the Affordable Care Act (ACA). These reports shall analyze the state options and make recommendations to the Committee for legislative action regarding the following topics:

(i) The feasibility of instituting a basic health program pursuant to Section 1331 of the ACA, including a proposed plan for implementation;

(ii) The impact of eliminating gender as a rating factor, limiting variation in community rates based on age, and limiting waiting periods for coverage, as required under the Act;

(iii) The impact of merging the individual and small group insurance markets on rates and coverage, including a proposed plan for implementation;

(iv) The feasibility of requiring insurance product consistency inside and outside of a state health insurance exchange, including an assessment of coverage and rate impacts; and

(v) The substantially equivalent utilization coverage limits that the legislature may substitute for the current dollar coverage limits on numerous state health insurance mandates, to conform with the Act.

This document is submitted in fulfillment of (i), the required report on the Basic Health Program.

**Introduction**
One of the major goals of the Affordable Care Act (ACA) is to ensure as many people as possible have access to and avail themselves of affordable health insurance. The ACA seeks to accomplish this goal through several major initiatives.

First is the imposition of an individual mandate. Most individuals will be required to have health insurance or potentially pay a penalty for noncompliance. The mandate requires individuals to maintain minimum essential coverage for themselves and their dependents. Certain individuals will be exempt from the mandate, including those for whom coverage is unaffordable or who are in a hardship situation.[1]

Second is the establishment of Health Insurance Exchanges. These Exchanges are envisioned as marketplaces for individuals and small businesses to purchase health care coverage. Monthly premiums and cost-sharing for health care coverage through the Exchange will be subsidized by the Federal government for those individuals earning less than 400% of the Federal Poverty Level (FPL).[2] While each State is required to have an Exchange, the Exchanges can be administered by the federal government, a state government, or a shared model. Rhode Island has opted for a State-based Exchange.

Third is an optional expansion of Medicaid to all persons with incomes under 138% of the FPL.[3] The EOHHS intends to seek General Assembly approval to implement this expansion to the Rhode Island Medicaid program. If approved, childless adults meeting the income guidelines will be Medicaid-eligible in 2014.

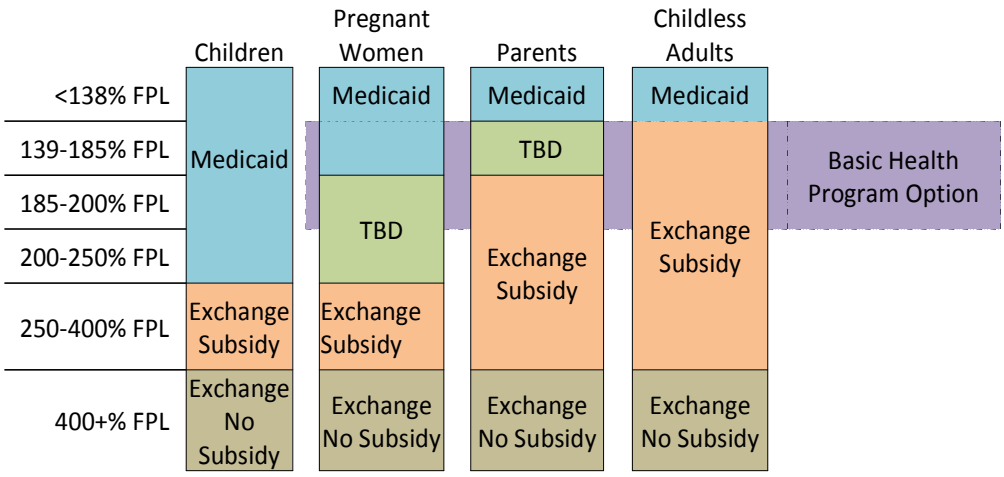
These three initiatives lay the basic framework for access to health care coverage. There is a concern, however, that these three efforts alone will not actually enable access to *affordable* coverage for everyone. This concern is primarily focused on those individuals and families with household incomes between 138% and 200% of the FPL. If these individuals need to access health insurance coverage through the commercial market, the monthly premiums and cost-sharing requirements, even when subsidized, may simply be too expensive.

The ACA includes a provision that provides States the option to establish a Basic Health Program for low-income individuals not eligible for Medicaid. This option might enable a State to address the issue of affordability. The chart below reflects who in Rhode Island would potentially be eligible to participate in a Basic Health Program.

[1] http://healthreform.kff.org/~/media/Files/KHS/docfinder/8222011_CRS_individual_mandate.pdf
[2] In this document, we make several references to income levels as a percentage of the Federal Poverty Level. We have included in **Appendix A** a chart reflecting the current Federal Poverty Levels.
[3].This equates to an annual salary of slightly under $15,000 for an individual. The ACA sets the eligibility limit at 133% of the federal poverty level (FPL) in 2014, but instructs states to disregard an amount of income that brings the household to 138% of the FPL. ACA, Section 2001(a); Health Care and Education Reconciliation Act, Pub. L. No. 111-152 Section 1004(e)

Basic Health Program

Allows states to cover individuals with incomes between 138 and 200% of poverty through a state-run program




The chart reflects some decisions that Rhode Island still needs to make concerning how currently Medicaid eligible pregnant women between 185% - 250% FPL and parents from 133% - 175% will access coverage. The ACA does impose maintenance of effort requirements that, in Rhode Island, would maintain Medicaid coverage for children up to 250% FPL and pregnant women up to 185% FPL through September 30, 2019.

This report will discuss EOHHS' overall goals in the implementation of the ACA and how EOHHS has considered the Basic Health Program opportunity in light of those goals.

This report identifies many areas in which EOHHS needs further guidance from the federal government or needs to conduct further analyses. We consider this report to be the first in a series of informational reports to the Joint Committee. We intend to update the information in this report and to issue other reports on additional aspects of the ACA as more guidance is issued and as we are able to complete more analyses.

This report will focus on individuals who become eligible for Medicaid based solely on their income. The ACA changes to Medicaid eligibility that are discussed here do not impact persons eligible for Medicaid based on a disability. Nor does this report address issues for Medicaid eligible persons over age 65.

**EOHHS Health Reform Goals and the Affordable Care Act**

EOHHS Secretary Steven M. Costantino has expressed a vision of a publicly-financed health care system that encompasses the following principles:

- The publicly-financed health care system, including Medicaid, should offer health care that is affordable, easy to access, and responsive to people's needs.

- The publicly-financed health care system needs to use each public dollar it spends efficiently and effectively.

- As its primary mission, the Medicaid Program should provide direct access to health care coverage for eligible persons when no other coverage is available.

- When Medicaid-eligible individuals have access to affordable and responsive health care coverage through the commercial market, Medicaid should support and enable access to that coverage.

- When Medicaid-eligible individuals have access to affordable commercial health care coverage that is comprehensive but may not meet specific special needs, Medicaid should support and enable access to that commercial coverage but should also provide Medicaid-funded wrap-around services. Those wrap-around services should be integrated with primary, acute, and specialty services and should seek to improve or maintain the health of the individual; improve the quality of care received; and be cost-effective.

Rhode Island has historically valued access to comprehensive insurance coverage. This is reflected in the current Medicaid eligibility levels in place for children and families; eligibility levels that significantly exceed the mandatory levels. One of the reasons that Rhode Island was compelled to expand coverage to these levels is that these families, at the time, had limited access to affordable insurance coverage in the commercial market. The need to establish programs such as RIte Care[4] reflected a gap in insurance coverage that the private sector did not meet and that the public sector sought to fill.

At the same time, programs such as RIte Share[5] reflected the principle that if people did have access to commercial coverage; they should avail themselves of that coverage and Medicaid should assist. The design of the eligibility requirements for the Rhode Island Medicaid program reflects a response to the opportunities for health care coverage that did or did not exist in the commercial market.

The same is true today. The ACA fundamentally reforms insurance in the commercial marketplace. Through the establishment of Exchanges; federal subsidies for monthly premiums and cost-sharing; the required Essential Health Benefits; and other ACA initiatives, access to

[4] RIte Care is Rhode Island's Medicaid managed care program for families on the RI Works Program and eligible uninsured pregnant women, children, and parents. Members enroll in a participating health plan: United Healthcare of New England or Neighborhood Health Plan of RI.

[5] RIte Share is Rhode Island's Premium Assistance Program that helps Rhode Island families afford health insurance through their employer by paying for some or all of the employee's cost.

commercial coverage is greatly enhanced. Given these changes, EOHHS needs to examine Medicaid and understand its appropriate role in this new environment.

With the expansion of insurance options in the commercial marketplace, the ACA provides EOHHS an opportunity to narrow its focus and to target its publicly financed services to those most in need. For example, at the same time that Medicaid seeks to expand coverage to uninsured childless adults under 133% FPL; it has the opportunity to move currently eligible parents at 138% – 175% FPL from Medicaid to the Exchange. While this action could generate substantial savings, it is not immediately clear that it is the best policy decision for Rhode Island. Would parents at those income levels be able to afford the premiums and cost-sharing associated with coverage through the Exchange, even with federal subsidies? If not, will these parents opt to pay the penalty and forego coverage all together?

Questions of affordable coverage exist for other people whose income falls between Medicaid eligibility and 200% FPL; or for whom Medicaid is not available – this includes childless adults between 138% and 200% FPL as well as legal immigrants who have been in the country for less than five years and are therefore ineligible for Medicaid. Are the individual mandate and the subsidies offered through the Exchange sufficient to achieve the goal of affordable comprehensive coverage for this population? If not, what options does the State have to address the issue?

This report will provide the context for the consideration of a Basic Health Program, including affordability and continuity of coverage. It will present some different options to address those primary issues. It will conclude with some recommendations on potential next steps.

**Current Environment**

Today, the RIte Care Program is available to eligible children in families with household incomes up to 250% FPL and to parents of those children up to 175% FPL.

Currently through RIte Care, parents and children who are both Medicaid eligible are considered a family unit and are in one health plan together. Families in households with incomes above 175% FPL have coverage for children through RIte Care but parents are either uninsured or access coverage through other public programs or the commercial market.

Under Rhode Island law, households at 150% FPL and above are required to contribute to the cost of their RIte Care coverage. RIte Care monthly premium cost for families is at a family unit level. So, if a family of four and a family of two are both at 150% FPL, both families pay the same premium amount.

The following table outlines these cost-sharing requirements:

| Federal Poverty Level | Monthly Premium |
|---|---|
| 133% - 150% | $0 |
| 150% - 175% | $61 |
| 175% – 200%[6] | $77 |
| 200% - 250%[6] | $92 |

Rhode Island statute requires that when a RIte Care family does not pay their premium share after two consecutive months, they are sanctioned. The sanction removes all household members from health coverage for four (4) months.

**What changes in 2014?**

In 2014, EOHHS will continue to cover children up to 250% FPL in RIte Care and parents of these children up to 138% FPL. EOHHS will seek legislative approval to expand the Medicaid program to childless adults up to 138% FPL**. One of the questions the State must answer is what will happen to currently eligible parents with incomes above 138% FPL?**

[6] At this income level, only children are eligible for Medicaid

## Options

### 1. Standard Implementation of the ACA

Under a standard implementation of the ACA, currently eligible RIte Care Parents from 138% - 175% FPL and childless adults from 138% and above would access coverage through the Exchange.

The standard implementation of the ACA is an attractive option for the State because it would result in substantial savings to the Medicaid Program. The currently enrolled population of 6,515 parents at 138%- 175% FPL would be projected to go to the Exchange. Total current cost within Medicaid for this population is approximately $22.5 million ($11.2 in General Revenue). If this population goes to the Exchange, it will reduce Medicaid expenditures by this amount. EOHHS' stated policy and historic tradition of supporting a person's access to available, affordable commercial coverage also supports this approach.

There are, however, concerns about the impact this decision may have on currently eligible parents and individuals whose incomes are slightly higher than Medicaid eligibility levels. The two primary concerns are the affordability of coverage offered through the Exchange and the disruption that occurs when coverage options change (moving from commercial coverage to Medicaid, for example).

### The Affordability Issue

We will discuss affordability in terms of monthly premiums and point-of-service out-of-pocket cost-sharing.

Rhode Islanders with incomes above 138% FPL who seek health care coverage through the Exchange will be obligated to contribute 3.3% of their income for subsidized coverage through the Exchange. For a person at 139% FPL, this would equal about $49 a month. Out of pocket expenses through the Exchange could run as high as $174 per month for the same individual.[7]

People in households at 175% FPL today are all eligible for RIte Care and pay $77 a month for that coverage. There are no point-of-service cost-sharing requirements in RIte Care.

If the parents were to begin accessing coverage through the Exchange in 2014, their cost-sharing (including monthly premiums and out-of-pocket expenses) could be as high as $143.37. Additionally, the parents would continue to pay the RIte Care monthly premium of $77. We estimate that the maximum health care costs for this family would be $220.37 a month. Is this affordable?

Our experience in RIte Care indicates that many families at these income levels find it difficult to pay for health care. In SFY 2012 – 1,904 families were sanctioned at some point for non-payment of premiums. Currently there are 5,494 active families with incomes between 150% - 200% of FPL. In SFY 2012, 35% of families lost RIte Care coverage for failure to pay the premium cost- share.

[7] Maximum out-of-pocket cost sharing will be estimated $2,083 per year in 2014 for families below 200% FPL. However, the actual out-of-pocket cost-sharing that members will pay depends on the amount of care they use. Kaiser Family Foundation, "Health Reform Subsidy Calculator"

If EOHHS were to propose moving parents from 138% - 175% FPL from Medicaid to the Exchange, the following chart illustrates the difference in cost-sharing.

**Out of Pocket Costs for Certain Families: Parents who Access Insurance through the Exchange and Children who Access RIte Care**

| FPL Level | Annual Income Family of 3 | Monthly Income Family of 3 | Monthly Out of Pocket Cost for RIte Care | Maximum Costs Under Exchange: Monthly Premium and Out-of-Pocket | | Total Out of Pocket for Family |
|---|---|---|---|---|---|---|
| 138% | $26,344 | $2,196 | N/A | 3.3% | $72.46 | $72.46 |
| 150% | $28,635 | $2,386 | $61 | 4.0% | $95.45 | $156.45 |
| 175% | $33,408 | $2,784 | $77 | 5.2% | $143.37 | $220.37 |

**The Continuity of Care Issue**

Churning or the movement of people between different insurance coverage options is a natural consequence of an income-based insurance program. The movement of people from uninsured, covered by Medicaid, or covered by commercial coverage can be very disruptive to a person's ability to access care in a coordinated manner. When insurance status or coverage changes, a person may be unable to see the same providers and new prior authorizations for services may be applied. There is also a great deal of administrative burden associated with the determination and redetermination of a person's eligibility for programs.

Studies have indicated that low-income families could churn up to four times in a 12 month period. An article in Health Affairs indicates that in a 12 month period, 50% of adults with incomes below 200% FPL were found to experience a change in income that would have affected their eligibility.[8]

The population between138% and 199% FPL may be particularly prone to income fluctuations: an analysis of survey data from 2005-2006 found that 51% of adults between 138% - 199% FPL remained in the same income category at the end of one year, compared to 76% of those with incomes below 138% FPL and 73% of those with incomes between 200%-399% FPL.[9]

Does the transfer of parents from 138% -175% FPL from Medicaid to the Exchange exacerbate the churning issue? What will the experience of the new expansion population be? Given the above studies, we would anticipate significant movement between the Exchange and Medicaid for both these populations.

The standard implementation of the ACA would appear to have a negative impact on the affordability of coverage for parents at 138% - 175% FPL. It would also appear that these parents and others at these income levels experience disruptions in health care coverage more frequently than others.

[8] Somers BD, Rosenbaum S. Issues in Health Reform; How Changes in Eligibility May Move Millions back and forth between Medicaid and Insurance Exchanges. Health Affairs. 2011; 30(2): 228-236.
[9] Short PF, Swartz K, Uberoi N, Graefe D. Realizing health reform's potential: Maintaining coverage affordability and shared responsibility when income and employment change. New York: Commonwealth Fund 2011

There are alternatives to the standard implementation approach. One simple way to mitigate the affordability issue would be to eliminate the RIte Care premiums. This would result in a revenue loss to the State of approximately $2 million in general revenue funds. This decision would assist the families who would continue to access Medicaid as well as those parents who would be accessing insurance through the Exchange.

Disruptions in care can be addressed through current efforts to transform the health care delivery system. These efforts include multi-payer reforms such as the Chronic Care Sustainability Initiative (CSI) and the affordability standards imposed by the Office of the Health Insurance Commissioner.

While these responses would help to mitigate these issues, they may not be sufficient or rapid enough to ensure that persons between 138% and 200% FPL are able to afford and remain in affordable, comprehensive health care coverage in 2014.

**Alternatives to Standard Implementation**

**2. Basic Health Program**

One of the ways States have explored addressing the issue of affordability and continuity of coverage is through a Basic Health Program (BHP). Section 1331 of the ACA provides states with the option to establish a Basic Health Program for low-income, uninsured individuals with incomes between 138%-200% FPL. This includes lawfully present aliens who are not eligible for Medicaid because they have lived in the United States for less than five years. To be eligible for BHP state residents must be under age 65 and not eligible for Medicaid, other minimum essential coverage, or for employer-sponsored coverage that is "affordable," as defined by the ACA. Individuals eligible for the BHP are not eligible for the Exchange.

**In Rhode Island, who would be covered under a Basic Health Program?**
**It is important to note that if the State were to establish a BHP, it would serve a larger population than the parents at 138% - 175% who are currently eligible for Medicaid. The population to be covered would be all persons between 138% and 200% of FPL.** The table below outlines the low-income parents who would be affected if Rhode Island chooses a BHP option.

**Parents Currently Eligible For Medicaid Who Would Potentially Be Eligible for BHP, by Insurance Status**

| **Federal Poverty Levels** | **133% - 149%** | **150% - 174.9%** | **Total** |
|---|---|---|---|
| Currently **Enrolled** in Medicaid* | 3,233 | 3,282 | 6,515 |
| Currently **Uninsured**, eligible for Medicaid but not enrolled** | 507 | 1,349 | 1,856 |
| Currently **Insured**, Eligible for Medicaid, not enrolled** | 701 | 1,582 | 2,283 |
| **TOTALS** | **4,441** | **6,213** | **10,654** |

*Rhode Island MMIS

**Based on EOHHS analysis of data from the American Community Survey, US Department of Commerce, US Census Bureau, 2012

Other populations beyond those reflected above, that is, any resident legally residing in the United States with incomes between 138% and 200% FPL would also potentially be eligible to enroll in the BHP.

**Parents Between 175% and 200% of FPL and Childless Adults Between 133% and 200% FPL Who Would Be Eligible for BHP, by Insurance Status***

| Federal Poverty Levels | 133-149% | 150-174.9% | 175-185% | 185-200% | TOTAL |
|---|---|---|---|---|---|
| **Parents** | | | | | |
| Uninsured | | | 748 | 610 | 1,358 |
| Insured | | | 975 | 1,307 | 2,282 |
| **Childless Adults** | | | | | |
| Uninsured | 3,606 | 3,186 | 4,350 | 1,512 | 12,834 |
| Insured | 3,951 | 5,743 | 6,252 | 2,794 | 18,740 |
| **TOTALS** | **7,557** | **8,929** | **12,505** | **6,223** | **35,214** |

*Op Cit., American Community Survey

**Potential BHP Population Estimates**

Although the above tables reflect the potential population eligible for enrollment in a BHP, we have made some estimates concerning the number who might actually enroll.

We have assumed that

- 100% of current parents 138%- 200% would enroll in the BHP;
- 80% of uninsured childless adults between 133-200% would enroll in the BHP; and
- 20% of currently insured 138% - 200% FPL would enroll in the BHP. We estimate 20% would switch from their existing coverage to the BHP because their current insurance is deemed not affordable.

| Population by Insurance Status | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Currently Enrolled in Medicaid* | | | Uninsured** | | | Insured** | | | Total |
| | | Proj. Take up Rate | Proj. BHP Enrollees | | Proj. Take up Rate | Proj. BHP Enrollees | | Proj. Take up Rate | Proj. BHP Enrollees | |
| Parents <175 Currently enrolled | 6,515 | 100% | 6,515 | | | | | | | |
| Parents <175 Not currently enrolled | | | | 1,856 | 80% | 1,485 | 2,283 | 20% | 457 | |
| Parents >175-<200 | | | | 1,358 | 80% | 1,086 | 2,282 | 20% | 456 | |
| Childless Adults 133-200% | | | | 12,834 | 80% | 10,267 | 18,740 | 20% | 3,748 | |
| Total Pop. | 6,515 | | | 16,048 | | | 25,505 | | | 45,868 |
| Total Proj. Enrolled in BHP | | | 6,515 | | | 12,838 | | | 4,661 | 24,014 |

*RI MMIS

**Op Cit., American Community Survey

We estimate approximately 24,000 Rhode Islanders would potentially enroll in a BHP.

**What services would be available?**
The BHP would need to offer all the minimum essential benefits that would be available under the Exchange. **The State would not be required to provide full Medicaid benefits to BHP enrollees.**

**What health care delivery system would be used?**
EOHHS has not conducted a thorough analysis of this question. If the State were to pursue a BHP, one option for the delivery system would be to replicate the one in place for the RIte Care or Rhody Health Partners program. That is, services would be delivered through one or more managed care organizations currently under contract with the State. This approach could leverage the established infrastructure of that program along with the existing experience of those plans with providing services to lower income adults. Medicaid managed care plans often have a lower PMPM cost than prevailing individual plans in the commercial market. To the degree this is true, a variety of factors may be at work, including specialized networks (particularly in the area of behavioral health); active focus on care coordination of complex cases; special programs such as Generic First pharmacy, Communities of Care. Medicaid managed care plans typically have lower administrative costs, including lower marketing costs, no costs for brokers.

**How would providers be affected by a BHP?**
If the State were to use the existing managed care delivery system, one option would be that the Medicaid Managed Care Organizations (MCOs) would reimburse providers at the same rates as are paid under the RIte Care program. Average payments to providers under RIte Care tend to be lower than prevailing rates under commercial plans. While lower provider payments assist the financial feasibility of a BHP to the State, providers face lower reimbursements than they would have received if BHP enrollees were participating in the Exchange. At the same time, Medicaid managed care reimbursement rates are higher than what providers would receive if BHP enrollees forego insurance coverage all together.

**How might a BHP impact Rhode Island's Health Insurance Exchange?**
The relationship between the Exchange and the BHP is a very important one as the design and costs of each Program is affected by the other.

If the State establishes a BHP, there will be fewer people accessing their insurance coverage through the Exchange. Depending on the Exchange revenue model, a successful, sustainable Exchange requires a broad pool of people purchasing coverage. If the Rhode Island Health Benefits Exchange used a per enrollee assessment, given the small population in Rhode Island, then the development of a BHP could threaten the viability of the Exchange. If the Exchange used a broad based revenue approach, there is less of a threat from a smaller pool. A smaller number of people in the Exchange might also hamper the Exchange's ability to operate as an "active purchaser." Under an "active purchaser model," an Exchange negotiates with health plans and seeks to introduce new service delivery options in order to reduce premiums and improve the quality of health care overall. If the Exchange has fewer participants, its negotiating power is reduced.

In addition to the number of people accessing coverage through the Exchange, it is possible that a BHP might impact the premiums charged for coverage through the Exchange. This concept is further explored under the discussion regarding the Financial Considerations of a BHP.

**What are the financial considerations of establishing a BHP?**
Ideally, the BHP would be financed solely with federal funding and enrollee cost of care, with no additional State funding required. The amount of available federal tax subsidy dollars is arrived at by first determining what the federal government would have spent on subsidies for an individual if that individual had accessed coverage through the Exchange. In an Exchange, federal subsidies will exist for monthly premiums as well as point-of-service cost-sharing. At this time, it is not clear if the BHP funding is equal to 95% of both the premium and cost-sharing subsidy or equal to 95% of the premium and 100% of the cost-sharing tax credits[10] that BHP enrollees would have received had they purchased coverage through the Exchange.

Under the statute, the amount of the tax subsidy dollars paid to the state will be based on a variety of factors including age, income, and whether enrollment is for individual or family coverage. The health status of the enrollee might also be taken into account in order to determine risk adjusted payments.

States can also charge monthly premiums and impose point-of-service cost-sharing on BHP enrollees. There are limits on this cost-sharing. Under the Exchange, coverage will be offered at one of the following levels: bronze, silver, gold, or platinum. These levels reflect the amount of cost-sharing that enrollees are required to pay. Platinum plans are expected to have the highest monthly premium, but represent the least amount of financial risk for the consumer. Bronze plans are expected to the have the lowest premiums, but may result in more out-of-pocket expenditure. Limits on the premium that can be charged in a BHP cannot exceed the premium share in the second lowest cost silver plan in the Exchange. Point-of-service cost-sharing for BHP enrollees under 150% FPL must not exceed 10% of the platinum tier levels and for BHP enrollees over 150% FPL, cost sharing may not exceed 20% of the gold tier levels.

At present, we do not believe there is sufficient information available to confidently forecast the amount of revenue from the federal tax subsidies or enrollee cost-sharing that might be available to fund a BHP. In order to determine the amount of revenue the State could reasonably assume to receive, the State would need to know the following[11]:

- The cost of second lowest cost silver plan
- The value of 95% of premium tax credit and cost sharing subsidies

The actual cost of the second lowest silver plan in Rhode Island's Exchange is essential to the calculation of anticipated revenue. This amount has not yet been determined. Further, the risk profile of the population enrolled in the second lowest silver plan would likely be affected by the presence or absence of the BHP population in the Exchange. People eligible to enroll in a BHP are relatively younger and poorer than the other populations who would be eligible for subsidies

[10] The statute is ambiguous as to whether the federal government will pay 100% of 95% of the cost-sharing credits. This is one of several issues that will need to be clarified.
[11] Deborah Bachrach, Melinda Durron, Jennifer Tolbert, Julia Harris. Focus on Health Reform, The Role of the Basic Health Program in the Coverage Continuum: Opportunities, Risks and Considerations for States. The Henry J. Kaiser Family Foundation.

through the Exchange (individuals at 200% – 400% FPL). Their low-income status would indicate poorer health status and therefore represent more financial risk to insurers. So, if BHP eligible enrollees were removed from the Exchange, it is possible that the people remaining in the Exchange would be healthier. This would result in lower premiums in the Exchange. However, potential BHP enrollees are also likely to be younger than Exchange eligibles. Younger age generally reflects better health status. It is possible that removing younger people from the Exchange would cause premiums in the Exchange to increase. The numbers of persons are small and the complete lack of experience the State has in having either an Exchange or a BHP make it extremely difficult to estimate what, if any, impact a BHP might have on the premiums charged through the Exchange.

There are also concerns about the impact of the Exchange's rates on the financial feasibility of a BHP. The lower the premiums on policies sold through the Exchange, the lower the dollar value for the subsidies and the less federal funding available to Rhode Island for the BHP.

In order to estimate the cost of administering a BHP, the State needs to understand:

- Demographics of the BHP population
- Benefits covered (EHB, Medicaid benchmark or standard, other)
- Provider network and provider reimbursement

Once the revenue and costs are determined, then the State will be able to determine what the BHP enrollee cost-sharing requirements would be.

Federal guidance on a host of issues has not been released and we have not received an indication that the information is imminent[12]. Areas where we need additional guidance include:

- The methodologies for the calculation of premium tax credits for the subsidy (including certification by the Chief Actuary of the Centers for Medicare and Medicaid Services (CMS);
- Whether the federal funds can be used for BHP administrative costs; if the subsidy amounts are at 95% or 100% of the Exchange point-of-service cost sharing requirements;
- The year-end reconciliation requirements associated with adjustments in tax credits or cost sharing due to changes in enrollee income during the year;
- Whether states might be able to include persons with employer sponsored coverage and operate a RIte Share-like program.

**Existing Analyses**

Despite the challenges in assessing the financial implications of the BHP, there have been two focused analyses of the BHP opportunity for Rhode Island. These are:

- Milliman, Inc. Milliman Issue Brief: Rhode Island Basic Health Program Analysis. Jeremy Palmer. March 7, 2011
- Wakely Consulting Group. Assessment of the Basic Health Plan Opportunity in Rhode Island. November 18, 2011

[12] CMS recently notified States that proposed rules regarding the Basic Health Program will be issued for comment in 2013 and final guidance in 2014, so that the program will be operational beginning in 2015 for states interested in pursuing this option.

The Milliman Report, commissioned by Neighborhood Health Plan of Rhode Island, compares estimated federal subsidy payments from the federal government with the estimated plan costs for members in the BHP. **In Milliman's analysis a significant surplus is projected for the state under the BHP.** The model necessarily incorporates several significant assumptions regarding the cost of medical services and the size of subsidy payments.

The Wakely Report, commissioned by the Office of the Health Insurance Commissioner using Exchange grant funding, similarly estimates the state's fiscal experience under the BHP, presenting several scenarios with varying assumptions on such factors as (a) the level of federal subsidies, (b) the costs of coverage within the BHP, and the impact of the presence or absence of a RIte Share-like program**. Depending on such factors and their underlying assumptions (e.g. risk profile of the BHP population, relative cost trends) some scenarios point to sizable deficits for the state, others to sizable surpluses.**

The estimates for both analyses rely on a set of assumptions about the future regarding the value of subsidies, the costs of the BHP, and federal decisions. As the time of this writing it is difficult to refine these analyses as little further guidance or information is presently available.

**Could a BHP result in any savings for the State?**
State general revenue savings would result from the movement of currently Medicaid eligible individuals to the BHP. If the State is able to administer a BHP at a lower cost than it receives in federal tax subsidies and patient cost-sharing, all funds must be reinvested in the BHP. The ACA requires that all funding be used solely for the BHP:

> "A State shall establish a trust for the deposit of the amounts received…and amounts in the trust fund shall only be used to reduce the premiums and cost sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State. Amounts in the trust fund and expenditures of such amounts shall not be included in determining the amount of any non-federal funds for purposed of meeting any matching or expenditure requirements of any federally-funded program.

Within specified limits, states have flexibility in the design of the BHP. Covered benefits must minimally include the essential health benefits but would not have to replicate the full Medicaid benefit package.

**Would a BHP pose any financial risk to the State?**
Yes; if federal payments and patient cost-share are less than the cost of the BHP, the state would be at risk for the excess cost. If necessary, a potential source of these state dollars could the savings generated from moving current Medicaid eligible parents from Medicaid to the BHP.

We began the exploration of a BHP to determine if the BHP could address our concerns on continuity of coverage and affordability for parents at 138% - 175% FPL. The consideration of a BHP requires us to think well beyond that population. Rather than determining a solution for 6,000 people, we would need to develop a program for potentially 24,000 or more.

In terms of the continuity of care question, the BHP would offer some level of continuity if the State chooses to use the Medicaid managed care delivery system. This continuity would only exist for persons moving between Medicaid and BHP. The same churning impacts would occur for people moving between BHP and the Exchange or other commercial coverage. At this time, it would appear that the State's overall efforts to transform the health care system for all Rhode Islanders hold more promise to address the issue of continuity of care than does the BHP.

As to the affordability question, it is likely that the costs to individuals in a BHP would be less than the costs for insurance in the Exchange, but it is not immediately clear that we could achieve that goal without additional State funding. At this time we do not have sufficient information to fully respond to the question.

**Some States, including Maryland, have acknowledged the dilemma of the many unknowns and are taking a wait and see approach. At this time, it appears Massachusetts, California, and Washington are pursuing a BHP option.[13] States that have already established programs for childless adults appear to be the States most likely to pursue this option.**

While we wait for the additional federal guidance on the BHP, we have also considered if there are alternative approaches to address the affordability question, specifically for the population about whom we are most concerned, parents at 138% - 175% FPL.

[13] http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=80

**3. Premium Subsidy in the Exchange**

Another alternative to the standard implementation approach is state funded premium subsidies for individuals in the Exchange. States concerned about the impacts on affordability and continuity of coverage/churn for coverage groups moving to the Exchange could consider making contributions to the costs of coverage within the Exchange.

In this case the State could act to reduce the out-of-pocket premium costs for parents by making a partial contribution to the costs of coverage within the Exchange. Different from the BHP, this approach could be specifically targeted to the population affected, parents from 138% - 175% FPL.

By way of example, the table below provides an illustration of potential associated costs for the State. Sample Calculations are described below.

*Increasing Affordability through State "Wrap" or Contribution to Increased Costs of Participation in Exchange vs. Current Family Costs in RIte Care*

1. Assume current cost to family of participating in RIte Care is maintained through premium for coverage of child/children.
    - Family Payment of RIte Care premium is required to be eligible for state contribution to cost of parent's participation in Exchange
    - For families between 150% - 175% of FPL this is $61 per month.
2. Identify ACA-specified maximum additional out-of-pocket costs for participation in Exchange
    - For parent in family of 3 at 150% FPL – 175%% FPL: $95.45 per month
3. Identify a State-Specified Maximum out-of-pocket level to make Exchange coverage more affordable for parents 133% - 175% FPL.
    - Scenario A: Hold Harmless
        - No additional cost to family above current cost to family for participation in RIte Care – i.e State pays the $95.45 on behalf of enrollee.
    - Scenario B: Shared Contribution
        - Enrollee contributes 25% of additional cost for participation in the Exchange, state contributes 75% - i.e. State pays $71.59, enrollee pays $23.86.
4. Estimate total number of parents impacted.
    - Currently enrolled parents – take up or transition to Exchange assumed at 100%
    - Currently uninsured parents – take up assumed at 80% of population.
    - Currently insured parents – take up assumed at 20%
5. Total State cost = total parents x subsidy amount x 12

This type of option would maintain the requirement of family contribution to the cost of coverage while addressing affordability. The impact on churn due to changes in income level, however, would appear minimal. Subsidy levels shown are illustrative and alternative subsidy levels could be considered. Current costs to Rhode Island for coverage for these parents are approximately $11.2 million in general revenue.

**Parents with Incomes 133% - 175% FPL**

| | **FPL 133% - 149%** | **FPL 150% - 175%** |
|---|---|---|
| Currently Enrolled in Medicaid and Estimated Future Enrollment in Exchange at 100% | 3,233 | 3,282 |
| Currently uninsured, eligible for Medicaid, not enrolled Estimated Future Enrollment in Exchange at 80% | 406 | 219 |
| Currently insured, Medicaid Eligible, not enrolled Estimated Future Enrollment in Exchange at 20% | 140 | 316 |
| Projected Total Enrollment in Exchange | 3,779 | 3,817 |

| **Estimated Cost to State at 100% Cost-sharing Subsidy** | **FPL 133% - 149%** | **FPL 150% - 175%** |
|---|---|---|
| Maximum out of pocket costs in Exchange | $63.47 | $95.45 |
| State Monthly Cost | $239,856 | $364,352 |
| State Annual Cost | $2,878,278 | $4,372,221 |
| Total Annual Cost | | $7,250,499 |
| Difference between current General Revenue Expenditures on Parents 138% - 175% FPL ($11.2 million) | | $3,949,501 |

| **Estimated Cost to State at 75% Cost-sharing Subsidy** | **FPL 133% - 149%** | **FPL 150% - 175%** |
|---|---|---|
| Maximum out of pocket costs in Exchange | $63.47 | $95.45 |
| State Cost (75%) | $47.61 | $71.59 |
| State Monthly Cost | $179,918 | $273,259 |
| Annual Cost | $2,159,018 | $3,279,108 |
| Total Annual Cost | | $5,438,127 |
| Difference between current General Revenue Expenditures on Parents 138% - 175% FPL ($11.2 million) | | $5,761,873 |

We have assumed that affected parents would no longer be Medicaid eligible and therefore, the costs of any such wrap payment are presented here as 100% state dollars. Some States considering a similar approach are pursuing whether such costs could be eligible for Federal financial participation through an 1115 Research and Demonstration Waiver. It is also unclear how the IRS would consider State subsidies; if the subsidies would be considered income and therefore have a negative impact on the amount of federal cost-sharing subsidies available. EOHHS will continue to develop this alternative approach and seek guidance from the Federal government on its potential feasibility.

4. **Bridge Option**

In guidance issued on December 10, 2012, CMS indicates that States may pursue the development of a "bridge" plan. Under this option, a state could allow a Managed Care Organization that offers a Medicaid product to offer a qualified health plan in the Exchange on a limited-enrollment basis to certain populations. A bridge plan would allow individuals who transition from Medicaid to the Exchange to remain with the same health plan. The following chart reflects a potential scenario of a family in Rhode Island under 150% FPL with differing insurance coverage:

| **Family Member** | **Eligibility Status** | **Insurer** |
|---|---|---|
| Father | Eligible for Premium Tax Credits and Cost-sharing assistance through Exchange | Exchange Qualified Health Plan |
| Mother (pregnant) | Medicaid and then Eligible for Premium Tax Credits and Cost-sharing assistance through Exchange | Medicaid MCO and then Exchange Qualified Health Plan |
| Child | Medicaid | Medicaid MCO |
| Baby | Medicaid | Medicaid MCO |

The Bridge Option seeks to keep the family in one health plan but at the same time retain the ability of the mother and father to receive premium tax credits and cost-sharing assistance through federal subsidies. It is not clear at this time, how a bridge plan might address the affordability question.

Tennessee has proposed to the Federal government a version of a bridge plan.[14] Tennessee proposes to do this by having the federal government recognize Medicaid MCOs as silver-level plans. Enrollment in a silver level –plan would enable the parents to qualify for significant cost-sharing subsidies. Tennessee requests that Medicaid MCOs be recognized as silver-level qualified health plans without having to meet the guaranteed coverage requirements. In other words, the Medicaid MCOs would only serve those individuals who are related to a Medicaid-eligible person.

Also, Tennessee seeks to ensure that the Bridge products are excluded from the benchmark plan determination. This would ensure that the Bridge option from "unduly influencing the value of the benchmark plans in Tennessee."

Tennessee is pursuing this approach as an alternative to the Basic Health Program. Tennessee's analysis of the Basic Health Program "suggests that the state could incur an unacceptable level of financial risk, and the income limit to the BHP program (i.e., 200% FPL) would not prevent the type of churning that the bridge product is designed to address." Tennessee's report also indicates a belief that the BHP would have a potentially negative impact on the composition of the individual market risk pool in the State.

EOHHS will continue to analyze the Bridge Option and its potential application to Rhode Island.

[14] http://www.tn.gov/nationalhealthreform/forms/onefamily.pdf

**Conclusion**

EOHHS is directed to issue a report to the Joint Committee on Healthcare Oversight on the feasibility of instituting a basic health program pursuant to Section 1331 of the ACA, including a proposed plan for implementation.

EOHHS believes that due to a lack of timely guidance from the Federal government, it is not reasonable for the State to begin the development of a BHP. We are unable to confirm, with any degree of certainty, that a BHP would not put the State at financial risk. Nor can we clearly state that a BHP would significantly address the question of affordability for individuals with incomes between 138% and 200% FPL. We also are unable to identify how a BHP would significantly impact issues concerning continuity of care.

That said, we are committed to continuing to actively explore and pursue the potential development of a BHP or other alternative approach to addressing the affordability and churning issue.

This report offers the General Assembly the following options to consider:

1. Standard Implementation of the ACA: end Medicaid coverage for non-disabled adults above 138% FPL. This would affect approximately 6,000 current Medicaid enrolled parents. As stated in this report, this option would save an estimated $11.2 million in general revenue funds but may pose some significant affordability challenges as well as frequent churning between insurance options for some people.

1a. Standard Implementation of the ACA with a removal of RIte Care monthly premiums. This option would help to address families' ability to afford coverage. This option would save the State an estimated $9.2 million in general revenue.

2. Basic Health Program: This approach would address not only the needs of the 6,000 currently eligible RIte Care parents, but would establish a potentially more affordable alternative to the Exchange for approximately 24,000 non-disabled adults. There is the potential for significant State financial risk under this option.
3. Premium Subsidy in Exchange: Under this option, the State would move current RIte Care parents into the Exchange, but would assist in their cost-sharing obligations. The ability to obtain Federal approval for this option is unclear.
4. Tennessee Bridge Option: This approach would enable families to remain with an insurer with experience with the Medicaid population and would also retain access to federal cost-sharing subsidies. The ability to obtain Federal approval for this option is unclear.

**An approach we did not describe but should be noted here is the option to maintain these parents in the RIte Care program for a period of time. One option would be to maintain Medicaid coverage until the Health Insurance Exchange has been developed and is operational.** This would enable EOHHS to better understand if current RIte Care parents can access affordable coverage through the Exchange. Additional time would also enable EOHHS to consider different alternatives and options for this population. This delay would mean that the State would continue to expend $11.2 million annually on this population.

As additional information becomes available, a more reliable estimate of the financial merits of the BHP and other options can be developed. We will be providing the Joint Committee with regular updates to this report as further guidance and information is available.

## Appendix A

## 2012 Federal Poverty Guidelines

| Family's Monthly Income (gross) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Family Size** | **100%** | **133%** | **138%** | **150%** | **175%** | **185%** | **200%** | **250%** |
| **1** | $931 | $1,239 | $1,285 | $1,397 | $1,629 | $1,723 | $1,862 | $2,328 |
| **2** | $1,261 | $1,677 | $1,740 | $1,891 | $2,206 | $2,333 | $2,522 | $3,152 |
| **3** | $1,591 | $2,116 | $2,196 | $2,386 | $2,784 | $2,943 | $3,182 | $3,977 |
| **4** | $1,921 | $2,555 | $2,651 | $2,881 | $3,361 | $3,554 | $3,842 | $4,802 |
| **5** | $2,251 | $2,994 | $3,107 | $3,376 | $3,939 | $4,164 | $4,502 | $5,627 |